GREENWICH HEALTH
PAIN | VENOUS | COSMETIC | REGENERATIVE
DARIEN | GREENWICH | MANHATTAN

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PATIENT CONSULTATION REFERRAL REQUEST

REFERRAL INFORMATION

Date of Request: _____/_____/_____

Referral Provider: _____

Phone #: (_____) _____ Fax #: (_____)_____

Primary Care / PCP (*if different*): _____

Patient Name: _____

Home Phone #: (_____) _____ Cell Phone: (_____) _____

REASON FOR REFERRAL:

Interventional Pain	Venous Medicine	Regenerative Medicine
☐ Knee, Hip, Shoulder Joint Pain	☐ Ultrasound-guided Vein Mapping	☐ Bursitis of Major Joints
☐ Spine Pain – Neck, Upper / Lower Back	☐ Varicose Vein / Varicosities	☐ Tendon and Ligament Pathology
☐ Degenerative Disc Disease / Bulges	☐ Spider and Reticular Veins	☐ Osteoarthritis (Early to Moderate)
☐ Disc Herniation / Radiculopathy	☐ Sclerotherapy – Liquid and Foam	☐ Patellar Tendonitis or Injury
☐ Sports Injuries / Optimizing Recovery	☐ Superficial Vein Disease	☐ Muscle Sprain and Tears
☐ Neuromodulation Therapies	☐ Chronic Venous Insufficiency	☐ Medial and Lateral Epicondylitis
☐ Headaches – General and Migraines	☐ Mechanochemical Based Treatments	☐ Plantar Fasciitis / Achilles Tendonitis
☐ Post-Surgical and Neuropathic Pain	☐ Minimally Invasive Closure Systems	☐ Facial Rejuvenation
☐ Sacroiliac Joint Pain	☐ Thermal-Based Treatments	☐ Hair Restoration
☐ Chronic Regional pain Syndrome	☐ Non-Thermal Based Treatments	☐ Rotator Cuff and Labral Tears
☐ Other: _____	☐ Other: _____	☐ Other: _____

DOCUMENTATION TO BE INCLUDED:

☐ Office Notes with Medical Records of any Previous Treatments

☐ Insurance Card / Demographics and Referral (if necessary)

☐ List of Current Medications

☐ Copy of all Imaging Study Reports (MRI, CT, Myelogram, X-Ray, Venous Mapping, Vascular Imaging, or Other Relevant Studies)